Dissociative Amnesia Related to Pregnancy

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Abstract

Dissociative amnesia, formerly called psychogenic amnesia, involve disruptions or breakdowns of memory, consciousness or awareness, identity and/or perception – mental functions that normally operate smoothly. Dissociative amnesia is not the same as simple amnesia, which involves a loss of information from the memory, usually as the result of disease or injury to the brain. With dissociative amnesia, the memories still exist but are deeply buried within the person’s mind and cannot be recalled. However, the memories might resurface on their own or after being triggered by something in the person’s surroundings. This case highlights an uncommon presentation of dissociative amnesia related to pregnancy (German J Psychiatry 2007; 10: 119-121).

Keywords: Dissociative amnesia, functional amnesia, pregnancy

Case Report

A 28-year-old married woman was referred by the neurologist for an inability to remember important people in her life or key events of her life in the past four months referred a 28-year-old married woman. The patient had delivered her sixth child four months ago. The delivery was normal and uncomplicated. The family members noticed that following her discharge from the maternity ward, the patient would not acknowledge her new born or recall the events leading to her childbirth. There was no denial of pregnancy but she did not remember any personal information, identity or events leading to the labor. She continues to breast feed and takes an active interest in the care of the new born. The patient did not report of infanticide ideations. Mother-infant bonding was evident but the patient insisted that she did not remember the childbirth. Repeated probing by her family members about this conflicting behavior where her personal functioning was normal but autobiographical memory was impaired would not yield any response. Not all efforts by the family members to make patient recall past events and day-to-day activities were successful. The patient would continue to say, “I do not know” to any, queries regarding her other children. The Mini Mental Status Examination (MMSE) also revealed similar responses to all questions. There was no evidence of an altered sensorium or confusion state. Investigations including blood counts, chemistry, thyroid functions, Electroencephalogram (EEG) and the Magnetic Resonance Imaging (MRI) of the head were done to rule out any possible organic etiology for the memory loss. The tests did not reveal any abnormality. The patient was transferred to the inpatient psychiatric unit.

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for observation and further evaluation. She adjusted to the ward routine but continued to report of her memory loss and was found to have strained interactions with spouse. The spouse lived abroad and patient would be irritable in her telephonic conversations with the spouse. He conveyed to the treating team that the patient would get irritable when he tried to test her memory. Repeated interviews did not help to achieve recall of her identity or events prior to the admission. The patient admitted to childhood sexual abuse in one interview. Mental status examination was done and no pervasive mood changes were observed. There was no evidence of agitation, crying spells, suicidal ideations, low mood or psychotic symptoms. There was some evidence of psychic numbing and emotional detachment but patient did not report of flashbacks, avoidance, and intrusive memories, hyperarousal symptoms related to the current pregnancy or childbirth. There was no evidence of post partum depression or psychosis according to the ICD-10 criteria. The patient fulfilled the ICD-10 guidelines for dissociative amnesia. The patient was administered the Dissociative Disorders Interview Schedule (Ross et al.; 1989) and she met the criteria for dissociative amnesia. The patient was tempted to clarify the diagnosis further using 2.5% of the thiopentone interview was attempted to clarify the diagnosis further using 2.5% of the drug given in doses of 0.5 and 0.75 g infused intravenously over 45 to 60 minutes. A written informed consent was administered to the patient and family member prior to the thiopentone interview. Gradually during this state of narcosis, the patient reported that the current pregnancy was a major stressor. This was her sixth pregnancy and she felt ‘physically drained’ and did not want to continue with the pregnancy. The spouse refused to terminate the pregnancy and there were conflicts with the spouse regarding terminating pregnancy in the first trimester. There were no alterations with the spouse in the subsequent months leading to the delivery. Following the thiopentone interview efforts were made by using “cues” related to events leading to her pregnancy and childbirth so that patient’s memory could improve. She continued to describe being in a ‘daze’ in the third trimester, unable to recall labor and childbirth. The patient reported that she did not remember any event leading to her delivery but continues to follow the instructions of the family members in caring for the child. The patient acknowledges the child because family members insist that she has given birth to the newborn. In an attempt to treat her amnesia, the patient was taken up for hypnosis. Suggestion in the trance state was attempted over 6-8 sessions regarding events leading to her pregnancy and childbirth. The patient showed partial improvement in her autobiographical memory. The patient was given memory assignments regularly based on personal event recall. These tasks gradually helped to facilitate spontaneous efforts by the patient to recall and narrate her personal events. She started to initiate conversations with the spouse and family members about events leading to the pregnancy. The patient was treated initially with low dose benzodiazepines (alprazolam 0.5mg) for occasional sleep disturbances. The drug was tapered and stopped at the time of discharge. The patient gradually improved and showed significant improvement at 12-week follow up. Thus, a combination of hypnosis and memory enhancing tasks were useful in facilitating recovery.

Discussion

Dissociative experiences during pregnancy and childbirth have been reported (Smith VM, Farkas A; 2006). The prevalence of dissociative amnesia in pregnancy and postpartum are not known. The predominant disturbance in this patient was an inability to recall important personal information. The primary symptom is typically profound retrograde amnesia. Memory for personal events is typically more severely impaired than memory for public events. Historically, the psychoanalytic (Freudian) concept of repressed has been invoked to “explain” functional amnesia. The supposition is that current life circumstances or personal memories that cause unbearable anxiety are actively made inaccessible to the conscious self (Wong, 1990, Kazniak et al.; 1998). Abeles and Schilder (1935) concluded from their analysis of 63 cases of psychogenic fugue that “on the whole, amnesia is a weak attempt by a weak personality to escape conflicts which are chiefly conflicts of actual life. Amnesia has also been described as an act of self-preservation (Stengel E; 1941) and often an alternative to suicide (Domb & Beaman, 1991). Did the amnesia serve as an act of self-preservation or an alternative for suicide in our patient? Arrigo and Pesdek (1997) describe six other classes of traumatic events that can trigger functional amnesia: adult rape, disasters and accidents, combat, attempted suicide, criminal acts, and violent death of a parent in childhood. Our patient had an initial conflict with spouse regarding continuation of the pregnancy and this could have been a stressful life event that triggered the amnesia after childbirth. It may be worth noting that symptoms of dissociation and emotional detachment have been described in posttraumatic stress disorder but the International Classification of Diseases (ICD-10) diagnostic guidelines of repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams in the presence of a traumatic event of exceptional severity are not satisfied. However, diagnostic guidelines (ICD-10) of amnesia either complete or partial for recent events that are of a traumatic or stressful nature and absence of organic brain disorder, intoxication or excessive fatigue for dissociative amnesia are satisfied. Therefore, a diagnosis of dissociative amnesia is justified in this patient. Kopelman (2000) has developed an elaborate neurocognitive model of how psychosocial factors might interact with brain systems to produce pure retrograde amnesia. The model postulates that severe stress operates on the brain’s executive control system to inhibit the retrieval of autobiographical and episodic information. When such stresses are particularly severe, they may even affect the brain’s “personal semantic belief system,” resulting in loss of identity. This system is proposed to be independent of the mesial temporal/diencephalic memory system that supports the formation of new episodic memories. Others have proposed neurochemical models of functional amnesia after acute stress or prolonged exposure to stressful life events. These focus on alterations in neuropeptides and neurotransmitters released during stress that modulate the formation and recall of memories of the trauma (Markowitsch HJ; 2002, 2003 and Bremner et al.; 1996). However, there are reports of isolated disproportionate retrograde amnesia in the organic amnestic syndrome (Stuss and Guzman; 1988),
These authors (Stuss and Guzman; 1988) described a patient with severe and disproportionate retrograde amnesia in the setting of a new onset seizure disorder and Klüver-Bucy syndrome. Electroencephalography (EEG), Magnetic Resonance Imaging (MRI), and positron emission tomography (PET) all revealed unambiguous bilateral temporal lobe pathology and were consistent with herpes simplex encephalitis. However, the administration of amobarbital sodium (Amytal), a provocative test for psychogenic amnesia, elicited detailed descriptions of many specific events from all stages of the patient's life. The authors speculated that the sedative drug might have released a retrieval "block" imposed by the brain lesion. O'Connor et al (1992) described a patient who developed severe retrograde amnesia, particularly for autobiographical information, without significant verbal learning deficits, also after an episode of herpes encephalitis. There was no clinical, laboratory or neuroimaging evidence to suggest an organic amnestic syndrome due to seizures, head trauma or encephalitis in our patient. Therefore it is possible to postulate that the current 'unwanted' pregnancy and lack of spousal support were important psychosocial factors that mediated the functional amnesia in our patient.

Dissociative amnesia occurs when a person blocks out certain information, usually associated with a stressful or traumatic event, leaving him or her unable to remember important personal information. With this disorder, the degree of memory loss goes beyond normal forgetfulness and includes gaps in memory for long periods of time or of memories involving the traumatic event. The patient's clinical state reflects the above description. Dissociative amnesia is uncommon but should be recognized during pregnancy and postpartum.

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